BERISH STRAUCH, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY
AESTHETIC SURGERY
SURGERY OF THE HAND

PROFESSOR AND CHAIRMAN
DEPARTMENT OF PLASTIC AND RECONSTRUCTIVE SURGERY
ALBERT EINSTEIN COLLEGE OF MEDICINE
MONTEFIORE MEDICAL CENTER

3331 BAINBRIDGE AVENUE
BRONX, NEW YORK 10467
TELEPHONE: 212-920-5551
FAX: 212-798-0909

1123 PARK AVENUE
NEW YORK, NEW YORK 10028
TELEPHONE: 212-534-5550

September 5, 1991

To Whom it May Conern,

Re: Ron Giladi

Please be advised, Mr. Giladi is to be scheduled for a decompression of his left median nerve at the wrist and the left ulnar nerve at the elbow and wrist.

If there is any further information I can provide, I would be most happy to do so.

Sincerely,

Berish Strauch, M.D.

BS:ew

006075

BERISH STRAUCH, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY
AESTHETIC SURGERY
SURGERY OF THE HAND

PROFESSOR AND CHAIRMAN
DEPARTMENT OF PLASTIC AND RECONSTRUCTIVE SURGERY
ALBERT EINSTEIN COLLEGE OF MEDICINE
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BRONX, NEW YORK 10467
TELEPHONE: 212-920-5551
FAX: 212-798-0909

1123 PARK AVENUE
NEW YORK, NEW YORK 10028
TELEPHONE: 212-534-5550

October 21, 1991

To Whom It May Concern,

Re: Ron Giladi

Mr. Giladi is scheduled for decompression of his left median nerve at the wrist and the left ulnar nerve at the elbow and wrist. Post-operatively, Mr. Giladi will require a 4 week healing period.

If there is any further information I can provide, I would be most happy to do so.

Sincerely,

Berish Strauch, M.D.

BS:ew

006076

BERISH STRAUCH, M. D.
PLASTIC AND RECONSTRUCTIVE SURGERY
AND SURGERY OF THE HAND
3331 BAINBRIDGE AVENUE
BRONX, NEW YORK 10467

TELEPHONE: (212) 920-5551

PROFESSOR AND CHIEF
PLASTIC SURGERY DIVISION:
ALBERT EINSTEIN COLLEGE OF MEDICINE
AND MONTEFIORE MEDICAL CENTER

February 4, 1992

To Whom It May Concern,

Re: Ron Giladi

Please be advised, the above captioned patient must continue his physical therapy as part of his recovery from the decompression of his median nerve. Physical therapy helps de-sensitize as well as full range of motion. This is the standard follow-up to a decompression surgery. Mr. Giladi is to continue his therapy until further notice.

If there is any further information I can provide I would be most happy to do so.

Sincerely,

Berish Strauch, M.D.

BS:ew

BERISH STRAUCH, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY
AESTHETIC SURGERY
SURGERY OF THE HAND

PROFESSOR AND CHAIRMAN
DEPARTMENT OF PLASTIC AND RECONSTRUCTIVE SURGERY
ALBERT EINSTEIN COLLEGE OF MEDICINE
MONTEFIORE MEDICAL CENTER

3331 BAINBRIDGE AVENUE
BRONX, NEW YORK 10467
TELEPHONE: 212-920-5551
FAX: 212-798-0909

1123 PARK AVENUE
NEW YORK, NEW YORK 10028
TELEPHONE: 212-534-5550

July 30, 1991

To whom it may concern,

Re: Ron Giladi

Mr. Giladi is a 39 year old Israeli Captian working as a video photographer at Albert Einstein College of Medicine, who on September 5, 1987, sustained a penetrating injury to his left forearm with incomplete severence of his left median nerve. He underwent repair at that time. More recently, he returned because of bilateral compression of his median nerve at the wrist as well as symptoms secondary to an cervical injury. EMG's and Conduction studies documented that bilateral median nerve compression at the wrist as well as bilateral ulnar nerve contrapments at his elbow. Additionally, there was a left C6 radicular function resulting in a mild degree of axon loss.

On physical examination, the patient has decreased sensibility in all of his digits as well as a weakness of his thenar musculature and long flexors to the little fingers.

I believe that until these clinical problems are resolved, Mr. Giladi will be unable to perform his usual activities during army service.

If there is any further information I can provide, I would be most happy to do so.

Sincerely,

Berish Strauch, M.D.

BS:ew
dictated but not read

006078

[redacted] Medical Center

PATIENT INFORMATION

Name (Patient) Roni GILADI (Head of Household) SAME

Address P. O Box 127 Millburn N. J. 07041
Street and number Town State Zip Co

Home telephone # — Social Security # 112-64-3264

Date of Birth 03-05-52 Age 39 Sex M

Current Marital Status: Single ____ Married ____ Separated ____ Divorced X

Occupation Video production Business telephone # 430-213

Name and Address of Employer Albert Einstin College of Medicine.
1300 Morris PARK Ave Bronx N.Y. 10461

Chief Complaint: Hand pain and loss of full control.

Is this problem due to recent or past injuries? If yes, explain: It is due
TO Past injuric. ([redacted])

Are you or have you been treated by a physician for illness (ie., diabetes, heart diseas
NO List: ____

Have you had any psychiatric or psychological examination or treatment? / Dates: ____

List all medication you are presently taking None

List any allergies to medications: None

Other allergies: None

Name and address of referring physician Dr Hall

Insurance (List all insurances covering both hospital/doctor and their ID numbers):
1199

Name of Insurance Company 1199 Telephone # ____

Address of Insurance Company ____

Feb - 25 - 1991
Date

006079

Signature

IMPORTANT: Use this form only when the Member becomes sick while employed or becomes sick or disabled within four (4) weeks after termination of employment. Otherwise use green claim form DB-300.

PART B HEALTH CARE PROVIDER'S STATEMENT (please print or type)

The health care provider's statement must be filled in completely and mailed to the Fund or returned to the member within seven (7) days of receipt of the form. For item 7d, give approximate date. Make some estimate. Delay in the payment of Disability Benefits may be prevented. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks."

1 Member's Name Roni (First) Giladi (Middle) Last (Print) 2. Age 39 3. ☐ Female ☐ Male

4 Diagnosis/analysis: Compression (L) ulnar nerve at elbow - Compression (L) Median nerve at wrist (ICD9/CPT4 CODE)

a Member's symptoms: pt reports weakness + pain + decreased sensibility of left hand

b Objective findings: EMG/NCS findings objectively c evidence of R/O Brkt. median nerve compression at wrist + ulnar nerve compression at elbow.

c. If disability is a result of pregnancy, give approximate date of conception: _____ date of confinement: _____

5 Member hospitalized? ☑ Yes ☐ No From Dec 12 1991 To Dec. 13 1991

Name of Hospital _____

6 Operations indicated? ☑ Yes ☐ No a. Type ulna nerve transposition at (L) elbow ulnar nerve release at (L) wrist + median nerve release at (L) wrist b. Date

7 Enter dates for the following:

	Mo.	Day	Year
a Date of your first treatment for this disability	02	25	91
b Date of your most recent treatment for this disability	1	3	92
c Date member was unable to work because of this disability	12	12	91
d Date member will be able to perform usual work	1	27	92

(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)

8 In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? ☐ Yes ☑ No

If "Yes," has Form C-4/48 been filed with the Workers' Compensation Board? ☐ Yes ☐ No

REMARKS (attach additional sheet, if necessary) _____

9 I affirm that I am a Physician (Physician, Podiatrist, Chiropractor, Dentist, Nurse-Midwife or Psychologist) Licensed in the State of NY License No. 085-986

Specialty _____ WCB Rating No. _____

Health Care Provider's signature Berish Strauch MD Date 1/6/92

Health Care Provider's name (please print) Berish Strauch MD Tel No. (212) 920535-7

Office address 3331 Bainbridge Ave (Number / Street) Bronx (City or Town) NY (State) 10467 (Zip Code)

(Must be furnished under authority of law) Indv. Practitioner's SS No. 062-26-3330 All others T.I.N. _____

REPORT OF SERVICES.

Date of Services	Place of Services	Description of Services Rendered	Procedure (CD9/CPT4	Charges
			Total	

AUTHORIZATION TO PAY BENEFITS TO HEALTH CARE PROVIDER: I hereby authorize payment directly to the Health Care Provider whose signature is above.

Member's signature _____ Date _____

COS080

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

IMPORTANT: Use this form only when the Member becomes sick while employed or becomes sick or disabled within four (4) weeks after termination of employment. Otherwise use green claim form DB-300

PART B HEALTH CARE PROVIDER'S STATEMENT (please print or type)

The Health Care Provider's statement must be filled in completely and mailed to the Fund or returned to the member within seven (7) days of receipt of the form. For item 7d give actual or due date. Make some estimate. Delay in the payment of Disability Benefits may be prevented. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks."

1 Member's Name Romi (First) G/ndi (Last) 2 Age ____ 3 ☐ Female ☐ Male

4 Diagnosis analysis Compression (L) ulna nerve at elbow & wrist compression (ICD9/CPT4 CODE)

a Member's symptoms (L) median nerve at wrist pt reports weakness w pain & decreased sensibility (L) hand

b Objective findings Pt. has extensive findings objectively c evidence of mild B/lat. median nerve compression at wrist & ulna nerve compression at elbow

c If disability is result of pregnancy, give approximate date of conception ____ date of confinement ____

5 Member hospitalized? ☒ Yes ☐ No From Dec 12 1991 To Dec 13 1991

Name of Hospital Montefiore Hospital Medical Center

6 Operations indicated? ☒ Yes ☐ No a Type ulna nerve neurolysis & transposition at left elbow, ulna nerve release at (L) wrist median nerve release at (L) wrist Date 12/12/91

7 Enter dates for the following

	Mo.	Day	Year
a Date of your first treatment for this disability	2	25	91
b Date of your most recent treatment for this disability	1	17	92
c Date member was unable to work because of this disability	12	12	91
d Date member will be able to perform usual work	2	17	92

(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)

8 In your opinion is this disability the result of injury arising out of and in the course of employment or occupational disease? ☐ Yes ☒ No

If yes has Form C-4/48 been filed with the Workers' Compensation Board? ☐ Yes ☐ No

REMARKS attach additional sheet if necessary ____

9 I am a Physician (Physician, Podiatrist, Chiropractor, Dentist, Nurse-Midwife or Psychologist) licensed in the State of NY License No 055586

Specialty Hand Surgery WCB Rating No ____

Health Care Provider's signature Joseph Bosco MD Date 1/17/92

Health Care Provider's name (please print) Bernard Strauch Tel No (212) 920-5351

Office address 3331 Bainbridge Ave (Number, Street) Bronx (City or Town) NY (State) 10467 (Zip Code)

Must be completed under authority of law. Indiv. Practitioner's SS No 162 26 3330 All others T.I.N ____

REPORT OF SERVICES

Date of Services	Place of Services	Description of Services Rendered	Procedure (CD9/CPT4	Charges
			Total	

AUTHORIZATION TO PAY BENEFITS TO HEALTH CARE PROVIDER I hereby authorize payment directly to the Health Care Provider whose signature is above

Member's signature ____ Date ____

003081

Tel-Hashomer
Department of Neurology

ID:		Invest No.:	1
Name:	Giladi Roni	Invest Date:	92.12.31
Date of Birth:	52.03.05	Age:	40
Sex:	M	Height:	180 cm

EMG Physician: M.Sadeh
Referring Department:
Referring Physician:

Clinical findings:
S/p operation for lt CTS and lt ulnar neurolysis (12.12.91).
Since the operation numbness in hand and fingers 4 and 5.

Reason for referral:
Evaluation of median and ulnar nerves.

Summary:
The lt median motor latency is borderline, but the sensory latency is markedly prolonged. The sensory distal latency of the rt median nerve is simillarly prolonged.
The lt ulnar motor distal latency is mildly prolonged. The velocity is normal between elbow and hand, but reduced along the ulnar groove at the elbow. There is no decrease in amplitude along the elbow. The sensory distal latency is prolonged and amplitude reduced to less than half of the rt side. Velocity is normal.

Diagnosis:
Bilateral CTS.
Ulnar neuropathy m/p due to injury at the elbow.

M. Sadeh, MD

006082

Form PLS-161 Arrangements MADE:

Dr. Nagashima 4493 5269 4316

MONTEFIORE MEDICAL CENTER

PLASTIC SURGERY

HOSPITAL ADMITTANCE

SS# 112 64 3226

DOB 3/5/52

NAME OF PATIENT Ron Giladi AGE 39. 39

ADDRESS PO Box 127 PHONE H. Tel (201) 576 76

Rilliston NJ 07041 W 212 930 213

REFERRING DOCTOR PHONE

ADMITTING DIAGNOSIS Compression Ulna Nerve (L) elbow & wrist
L Med. Nerve (L) wrist

LENGTH OF STAY IN HOSPITAL ~~2~~ 5 1/2 A 1 night p.o

INSURANCE COVERAGE 1199 - SS# ID.

OPERATIVE PROCEDURE 1) Neurolysis (L) ulna nerve & transposition elbow
2) " (L) ulna nerve wrist
3) Neurolysis ~~(L)~~ (L) Median N. + transposition wrist

LENGTH OF OPERATION 1 1/2 ANESTHESIA Gen.

ASSISTANT

CHARGE FOR OPERATION

ASSISTANT'S FEE

ADMITTING DATE PRE OP PICTURES

FEE DISCUSSED?

PATIENT NOTIFIED AND PRE OP APPOINTMENT AT OFFICE SET Nov 13 1991

REFERRING DOCTOR NOTIFIED? WCD @ 11 AM

re Assessment

Nov 11 1991

Mon 30 @ 3

ADMITTING DATE November 14, 1991

DATE OF SURGERY November 14 1991

006082

900105770

RR GILADI,RONI
POB127MILBOURNE NJ07041 12/12
P B.STR'AUCH PLS
11264326 4 N39 H 011-972-5334
0644 3890 0003 8121291

Dx: ULNAR NERVE COMPRESSION AT ELBOW + WRIST 64718-3500 64719-2500
MEDIAN NERVE COMPRESSION AT WRIST. 64721-2500
OR: NEUROLYSIS OF ULNAR N. AT ELBOW + WRIST, NEUROLYSIS OF MEDIAN N. AT WRIST

006083

LOCAL 1199
NATIONAL BENEFIT FUND
P.O. BOX 781
NEW YORK NY 10018

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

FORM APPROVED CMB NO. 0938-0008

☐ MEDICARE (MEDICARE NO.) ☐ MEDICAID (MEDICAID NO.) ☐ CHAMPUS (SPONSOR'S SSN) ☐ CHAMPVA (VA FILE NO.) ☐ FECA BLACK LUNG (SSN) XX ☐ OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
GILADI, RONI	07 | 09 | 53	GILADI, RONI
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. PATIENT'S SEX: MALE [X] FEMALE [ ]	6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)
P.O. BOX 127 MILLBURN NJ 07041		122643264
TELEPHONE NO.	7. PATIENT'S RELATIONSHIP TO INSURED: SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ]	8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
		☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)	10. WAS CONDITION RELATED TO:	11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
NONE REPORTED	A. PATIENT'S EMPLOYMENT: YES [ ] NO [X]	P.O. BOX 127 MILLBURN NJ 07041
	B. ACCIDENT: AUTO [ ] OTHER [ ]	TELEPHONE NO.
		11.a. CHAMPUS SPONSOR'S: STATUS: ACTIVE DUTY [ ] RETIRED [ ] DECEASED [ ] BRANCH OF SERVICE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

SIGNED SIGNATURE ON FILE DATE 12/17/91

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.

SIGNATURE ON FILE
SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES	16.a. IF EMERGENCY CHECK HERE ☐

17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM	THROUGH	DATES OF PARTIAL DISABILITY FROM	THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)	20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED	DISCHARGED
	12/12/91	12/17/91

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)	22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [X] CHARGES:
MONTEFIORE MEDICAL CENTER 111 E 210TH ST BRONX N	

23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE

1. 354.2 COMPRESSION ULNAR NERVE;ELBOW
2. 354.0 COMPRESSION MEDIAN NERVE;WRIST
3.
4.

B. EPSDT YES [ ] NO [ ]
FAMILY PLANNING YES [ ] NO [ ]
PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM	TO	B. * PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. * T.O.S.	H. LEAVE BLANK
12/12/91		IH	64718	NEUROLYSIS AND/OR TR ANSPOSITION;ULNAR NE	354.2	3500 00	1	2	
12/12/91		IH	64719	NEUROLYSIS AND/OR TR ANSPOSITION;ULNAR NE	354.2	2500 00	1	2	
12/12/91		IH	64721	NEUROLYSIS AND/OR TR ANSPOSITION;MEDIAN N	354.0	2500 00	1	2	

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)	26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES [X] NO [ ]	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
BERISH STRAUCH, M.D.		8500 00	0 00	8500 00
DATE: 12/17/91	30. YOUR SOCIAL SECURITY NO. 005084	31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.		
32. YOUR PATIENT'S ACCOUNT NO. 2214	33. YOUR EMPLOYER I.D. NO. 042263330	BERISH STRAUCH, M.D. 3331 BAINBRIDGE AVE. BRONX NY 10467 I.D.(212) 920-5551		

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS:

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (C-2) (1-84) Form OWCP-1500

TELEPHONE 920-5551

BNDD NO. AB1837078

BERISH STRAUCH, M. D.
PLASTIC & RECONSTRUCTIVE SURGERY
AESTHETIC SURGERY
SURGERY OF THE HAND

3331 BAINBRIDGE AVENUE BRONX, NEW YORK 10467

Name Ron Gladdi Age

Address Date 1/12/9

℞ S/P (L) ulna revo
Manolysis
RX – Active & passive
ROM

THIS PRESCRIPTION WILL BE FILLED GENERICALLY
UNLESS PRESCRIBER WRITES 'd a w' IN THE BOX BELOW

Dispense As Written

NOTICE [illegible] OF CLAIM FOR DISABILITY BENEFITS

IMPORTANT: Use [illegible] while employed or [illegible] weeks after termination of employment. Otherwise use [illegible]

PART B · HEALTH CARE PROVIDER'S STATEMENT (please print or type)

The health care provider's statement must be [illegible] completely and mailed to the Fund or returned to the member within seven (7) days of receipt of the form. For item 7-d, give approximate date. Make some estimate. Delay in the payment of Disability Benefits may be prevented. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks."

1. Member's Name: Roni (First) (Middle) Giladi (Last) 2. Age: 37 3. ☐ Female ☐ Male

4. Diagnosis/analysis: (ICD9/CPT4 CODE) Compression (L) ulnar nerve at elbow · Compression (L) median nerve at wrist.

a. Member's symptoms: pt. reports weakness + pain + decreased sensibility of left hand

b. Objective findings: pt. has extensive findings objectively c̄ evidence of mild B/LT. median nerve compression at wrist + ulnar nerve compress at elbows.

c. If disability is a result of pregnancy, give approximate date of conception: ______ date of confinement: ______

5. Member hospitalized? ☒ Yes ☐ No From Dec 12 1991 To Dec. 13 1991

Name of Hospital: [illegible]

6. Operations indicated? ☒ Yes ☐ No a. Type: ulna nerve transposition at (L) Elbow ulna nerve Release at (L) wrist + median nerve release at (L) wrist b. Date

7. Enter dates for the following:

	Mo.	Day	Year
a. Date of your first treatment for this disability	02	25	91
b. Date of your most recent treatment for this disability	1	3	92
c. Date member was unable to work because of this disability	12	12	91
d. Date member will be able to perform usual work	1	27	92

(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? ☐ Yes ☒ No

If "Yes," has Form C-4/48 been filed with the Workers' Compensation Board? ☐ Yes ☐ No

REMARKS (attach additional sheet, if necessary) ______

9. I affirm that I am a Physician (Physician, Podiatrist, Chiropractor, Dentist, Nurse-Midwife or Psychologist) Licensed in the State of NY License No. 085 986

Specialty ______ WCB Rating No. ______

Health Care Provider's signature: Berish Strauch MD Date: 1/6/92

Health Care Provider's name (please print): Berish Strauch MD Tel No. (212) 920555[illegible]

Office address: 3331 (Number) Bainbridge Ave (Street) Bronx (City or Town) NY (State) 10467 (Zip Code)

(Must be furnished under authority of law) Indv. Practitioner's SS No. 062 26 3330 All others T.I.N. ______

REPORT OF SERVICES.

Date of Services	Place of Services	Description of Services Rendered	Procedure CD9/CPT4	Charges
			Total	

AUTHORIZATION TO PAY BENEFITS TO HEALTH CARE PROVIDER: I hereby authorize payment directly to the Health Care Provider whose signature is above.

Member's signature ______ Date ______

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

IMPORTANT: Use this form only when the Member becomes sick while employed or becomes sick or disabled within four (4) weeks after termination of employment. Otherwise use green claim form DB-300.

PART B HEALTH CARE PROVIDER'S STATEMENT (please print or type)

The health care provider's statement must be filled in completely and mailed to the Fund or returned to the member within seven (7) days of receipt of the form. For item 7-d, give approximate date. Make some estimate. Delay in the payment of Disability Benefits may be prevented. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks."

1. Member's Name Ron (First) Gilad (Last) 2. Age ____ 3. ☐ Female ~~☐ Male~~

4. Diagnosis/analysis: Compression (L) ulna nerve at Elbow + Lt (ICD9/CPT4 CODE)

a. Member's symptoms: Compression (L) Median nerve at wrist pt reports weakness pain + sensibility (L) hand

b. Objective findings: Extensive findings objectively + evidence of mild bilateral median nerve compression at wrist + ulna nerve compression at elbow

c. If disability is a result of pregnancy, give approximate date of conception: ____ date of confinement: ____

5. Member hospitalized? ☑ Yes ☐ No From Dec. 12 1991 To Dec 13 1992

12/12/91 Name of Hospital Montefiore Medical Center

6. Operations indicated? ☑ Yes ☐ No a. Type Ulna nerve transpositon + trans position (L) elbow ulna nerve release at (L) wrist, median nerve release at (L) elbow b. Date ____

7. Enter dates for the following:

	Mo.	Day	Year
a. Date of your first treatment for this disability	2	25	91
b. Date of your most recent treatment for this disability	2	14	92
c. Date member was unable to work because of this disability	12	12	91
d. Date member will be able to perform usual work	3	8	92

(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? ☐ Yes ~~☐ No~~

If "Yes," has Form C-4/48 been filed with the Workers' Compensation Board? ☐ Yes ☐ No

REMARKS (attach additional sheet, if necessary) ____

9. I affirm that I am a Physician (Physician, Podiatrist, Chiropractor, Dentist, or Nurse-Midwife) Licensed in the State of NY License No. 085 582

Specialty Plastic Surgery TWCB Filing No. ____

Health Care Provider's signature Berish Strauch MD Date 2/17/9

Health Care Provider's name *(please print)* Berish Strauch MD Tel No. (212) 920 555

Office address 3331 Bainbridge Ave Bx NY 10467
Number Street City or Town State Zip Code

(Must be furnished under authority of law) Indv. Practitioner's SS No. 096 26 3330 All others T.I.N. ____

REPORT OF SERVICES.

Date of Services	Place of Services	Description of Services Rendered	Procedure 1CD9/CPT4	Charges
			Total	

AUTHORIZATION TO PAY BENEFITS TO HEALTH CARE PROVIDER: I hereby authorize payment directly to the Health Care Provider whose signature is above.

Member's signature ____ Date ____

NOTICE

IMPORTANT: Use this form only when the Member becomes sick while employed or becomes ... ment. Otherwise use green claim form DB-300.

PART B HEALTH CARE PROVIDER'S STATEMENT (please print or type)

The health care provider's statement must be filled in completely and mailed to the Fund or returned to the member within seven (7) days of receipt of the form. For item 7d, give approximate date. Make some estimate. Delay in the payment of Disability Benefits may be prevented, if disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks."

1. Member's Name Roni (First) G (Middle) Gindi (Last) 2. Age ____ 3. ☐ Female ☐ Male

4. Diagnosis/analysis: Compression (ICD9/CPT4 CODE) ulna nerve at elbow & wrist Compression

a. Member's symptoms: (c) median nerve at wrist pt reports weakness & pain & decreased sensibility (c) hand

b. Objective findings: Pt. has extensive findings objectively c evidence of mild Bilat. median nerve compression at wrist & ulna nerve compression at elbow

c. If disability is a result of pregnancy, give approximate date of conception: ____

date of confinement: ____

5. Member hospitalized? ☒ Yes ☐ No From Dec. 12 1991 To Dec 13 1991

Name of Hospital Montefiore Hospital Medical Center

6. Operations indicated? ☒ Yes ☐ No a. Type ulna nerve neurolysis & transposition at left b/w, ulna nerve release at (c) wrist median nerve release at (c) wrist b. Date #1 12/12/91

7. Enter dates for the following:

	Mo.	Day	Year
a. Date of your first treatment for this disability	2	25	91
b. Date of your most recent treatment for this disability	1	17	92
c. Date member was unable to work because of this disability	12	12	91
d. Date member will be able to perform usual work	2	17	92

(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? ☐ Yes ☒ No

If "Yes," has Form C-4/48 been filed with the Workers' Compensation Board? ☐ Yes ☐ No

REMARKS (attach additional sheet, if necessary) ____

9. I affirm that I am a Physician (Physician, Podiatrist, Chiropractor, Dentist, Nurse-Midwife or Psychologist) Licensed in the State of NY License No. 055956

Specialty Plastic & Reconstructive Hand Surgery WCB Rating No. ____

Health Care Provider's signature Berish Strauch MD Date 1/18/92

Health Care Provider's name (please print) Berish Strauch

Office address 3331 (Number) Bainbridge Ave (Street) Bronx (City or Town) NY (State) 10467 (Zip Code) Tel No. (212) 920 5351

(Must be furnished under authority of law) Indv. Practitioner's SS No. 116 24 3132 All others T.I.N. ____

REPORT OF SERVICES.

Date of Services	Place of Services	Description of Services Rendered	Procedure (CD9/CPT4	Charges

COS088 Total ____

AUTHORIZATION TO PAY BENEFITS TO HEALTH CARE PROVIDER: I hereby authorize payment directly to the Health Care Provider whose signature is above.

Member's signature ____ Date ____

1199 National Benefit Fund
FOR HOSPITAL AND HEALTH CARE EMPLOYEES
310 West 43rd Street, New York, N.Y. 10036 • Tel.: 212/307-7500

#208504 5500

Member's Name: Roni Giladi

Employed at: A.E.C.O.M.

Soc. Sec. No.: 112-64-3264

Date: June 27, 1992

Dear Member:

We are in receipt of your claim for benefits. In order to process your claim, it is necessary for you to complete this form and sign it.

Nature of illness or accident: _____

When and where did illness or accident occur? Give complete details dates: September 5, 1987

Was this illness or injury job related? Yes: _____ No: _____

Name of wife's / husband's place of employment:

Name: _____

Address: _____

Tel. No.: _____

Are you taking a legal action? If answer is "no", state why: _____

Do you, your spouse, or dependent have any other insurance which covers this claim _____ yes __XX__ no. If "yes", give name of company or union: _____

We will be able to process your application for benefits as soon as we receive the above information. If you need assistance regarding the above, please call the Benefit Fund Office at 307-7500 Extension ____

*Failure to respond timely may result in non-payment of your claim.

Fraternally yours,

1199 NATIONAL BENEFIT FUND

The undersigned has read and completed the foregoing statement affirms that the information is true to the best of his knowle

Member's Signature _____

COS089

coe:1199
3 NBF 19(Rev. 12/85)P

DETACH THIS PORTION FOR YOUR RECORDS

9 MEDICAL PLAN A+

11/91

Patient's Name
RONI GILADI

Social Sec. No.
112-64-3264

Account No.
2214

Claim No.
S12100291-00

oyee Information

RONI GILADI
P O ~~BOX 127~~
MILLBURN NJ 07041

PROVIDER	TOS*	DATE FROM — TO	TOTAL CHARGES	BASIC ALLOWED	MAJOR MEDICAL ALLOWED	MAJOR MEDICAL DED.	MAJOR MEDICAL %	MAJOR MEDICAL BENEFIT	TOTAL BENEFIT	C
AUCH	MC	022591-022591	100.00	0.00	0.00	0.00		0.00	0.00	¢
AUCH	SU	071991-071991	150.00	48.00	48.00	0.00	80	38.40	86.40	P
		TOTALS ➧	250.00	48.00	48.00	0.00		38.40	86.40	

e of Service
e Description

INITIAL CONSULT- SURGERY
SURGERY 20550

COB Adjustments	0.00
Other Adjustments	0.00
Total Payment Amount	86.40
Paid to Member	0.00
Paid to Provider	86.40
Non-Covered	154.00
Paid by Other Carrier	0.00

NO. 965451

marks

Description
OFFICE VISITS PERFORMED ON THE SAME DAY AS THERAPEUTIC PROCEDURE(S) ARE INCLUDED IN THE ALLOWANCE FOR THE PROCEDURE(S).
MAXIMUM BENEFIT PAID ACCORDING TO THE PLAN'S SCHEDULE OF ALLOWANCES.

DETACH THIS PORTION FOR YOUR RECO

an
9 MEDICAL PLAN A+
te
17/91

Patient's Name
RONI GILADI
Social Sec. No.
112-64-3264

Account No.
2214
Claim No.
S12210329-00

ployee Information

RONI GILADI
P O BOX 127
MILLBURN NJ 07041

PROVIDER	TOS*	DATE FROM — TO	TOTAL CHARGES	BASIC ALLOWED	MAJOR MEDICAL ALLOWED	MAJOR MEDICAL DED.	MAJOR MEDICAL %	MAJOR MEDICAL BENEFIT	TOTAL BENEFIT
RAUCH	MDS	073191-073191	50.00	27.50	4.50	0.00	100	4.50	32.0
*Type of Service Code Description		TOTALS ▶	50.00	27.50	4.50	0.00		4.50	32.0

DS FOLLOW-UP SPECIALIST VISIT

COB Adjustments	0.0
Other Adjustments	0.0
Total Payment Amount	32.0
Paid to Member	0.0
Paid to Provider	32.0
Non-Covered	18.0
Paid by Other Carrier	0.0

**Remarks
ode Description
3 MAXIMUM BENEFIT PAID ACCORDING TO THE PLAN'S SCHEDULE OF ALLOWANCES.

NO. 982782

CC0091

DETACH THIS PORTION FOR YOUR RECO

an
99 MEDICAL PLAN A+

te
/08/93

Patient's Name
RONI GILADI

Social Sec. No.
112-64-3264

Account No.
2214

Claim No.
S30360906-00

nployee Information

RONI GILADI
P O BOX 127
MILLBURN NJ 07041

PROVIDER	TOS	DATE FROM — TO	TOTAL CHARGES	BASIC ALLOWED	MAJOR MEDICAL ALLOWED	MAJOR MEDICAL DED.	MAJOR MEDICAL %	MAJOR MEDICAL BENEFIT	TOTAL BENEFIT
RAUCH	OV	011593-011593	50.00	13.75	3.75	0.00	100	3.75	17.50
TOTALS ➧			50.00	13.75	3.75	0.00		3.75	17.50

pe of Service
de Description

OFFICE VISIT

COB Adjustments	0.00
Other Adjustments	0.00
Total Payment Amount	17.50
Paid to Member	0.00
Paid to Provider	17.50
Non-Covered	32.50
Paid by Other Carrier	0.00

emarks
e Description

NO. 2268599

PROVIDER DID NOT INDICATE HIS/HER SPECIALTY. HAVE PROVIDER INDICATE SPECIALTY IN SPACE/RETURN TO PO BOX 781 NY 10018-6596.

006092

DETACH THIS PORTION FOR YOUR RECC

Plan
.199 MEDICAL PLAN A+

Date
)8/13/92

Ulnar nerve: elbow
median nerve wrist

Patient's Name
RONI GILADI

Social Sec. No.
112-64-3264

Account No.
2214

Claim No.
A20850455-01

Employee Information

RONI GILADI
P O BOX 127
MILLBURN NJ 07041

PROVIDER	TOS*	DATE FROM — TO	TOTAL CHARGES	BASIC ALLOWED	MAJOR MEDICAL ALLOWED	MAJOR MEDICAL DED.	MAJOR MEDICAL %	MAJOR MEDICAL BENEFIT	TOTAL BENEFIT
.TRAUCH	SU	121291-121291	3,500.00	575.00	460.00	0.00	100	460.00	1,035.0
STRAUCH	SU	121291-121291	2,500.00	479.00	383.20	0.00	100	383.20	862.2
STRAUCH	SU	121291-121291	2,500.00	524.45	419.56	0.00	100	419.56	944.0
TOTALS ➧			8,500.00	1,578.45	1,262.76	0.00		1,262.76	2,841.2

*Type of Service Code Description

:U SURGERY

64718

COB Adjustments	0.(
Other Adjustments	0.(
Total Payment Amount	2,841.2
Paid to Member	0.(
Paid to Provider	2,841.2
Non-Covered	5,658.
Paid by Other Carrier	0.(

**Remarks

NO. 1798282

Code Description

P1 MAXIMUM BENEFIT PAID ACCORDING TO THE PLAN'S SCHEDULE OF ALLOWANCES.

006093

PLEASE DETACH AT ABOVE PERFORATION

EXPLANATION OF BENEFITS

National Benefit Fund
FOR HOSPITAL AND HEALTH CARE EMPLOYEES
310 West 43rd Street
New York, N.Y. 10036

MEMBER ▶ RONI V GILADI
SSN ▶ 112-64-3264
PATIENT ▶ RONI V GILADI
EMPLOYER ▶ 001099

CLAIM NUMBER ▶ S40560273
CHECK NUMBER ▶ 00907621
DATE OF CHECK ▶ 05/18/1994
BENEFIT PLAN ▶ MEDICAL

SEE BACK OF FORM FOR A LISTING OF EXPLANATION CODES OR IF YOU HAVE ANY QUESTIONS.

Procedure Svc. Type	Dates of Service - Provider	Total Charge	Basic Allowed	Major Medical Allowed	Expl. Code	Tota Amou
99212	10/06/93-10/06/93	50.00	32.00	.00		32.
F/U VISIT SPECIALIST - STRAUCH, BERISH, M.D.						

TOTALS	32.0

006094

LOCAL 125
NATIONAL BENEFIT FUND
330 WEST 42nd STREET
NEW YORK NY 10036

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

FORM APPROVED OMB NO. 2938-0008

[ ] MEDICARE (MEDICARE NO.) [ ] MEDICAID (MEDICAID NO.) [ ] CHAMPUS (SPONSOR'S SSN) [ ] CHAMPVA (VA FILE NO.) [ ] FECA BLACK LUNG (SSN) [XX] OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
GILADI, RONI	03 / 07 / 52	GILADI, RONI
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	**5. PATIENT'S SEX**	**6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)**
P.O. BOX 127 MILLBURN NJ 07041	MALE [X] FEMALE [ ]	112645264
TELEPHONE NO.	7. PATIENT'S RELATIONSHIP TO INSURED: SELF [XX] SPOUSE [ ] CHILD [ ] OTHER [ ]	8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
		[ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)	**10. WAS CONDITION RELATED TO:**	**11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)**
NONE REPORTED	A. PATIENT'S EMPLOYMENT: YES [ ] NO [X]	P.O. BOX 127 MILLBURN NJ 07041
	B. ACCIDENT: AUTO [ ] OTHER [ ]	TELEPHONE NO.
		11.a. CHAMPUS SPONSOR'S: STATUS [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED — BRANCH OF SERVICE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

SIGNED: SIGNATURE ON FILE DATE: 02/26/91

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.

SIGNATURE ON FILE
SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES	16.a. IF EMERGENCY CHECK HERE
			[ ]
17. DATE PATIENT ABLE TO RETURN TO WORK	**18. DATES OF TOTAL DISABILITY** FROM / THROUGH	**DATES OF PARTIAL DISABILITY** FROM / THROUGH	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (eg. PUBLIC HEALTH AGENCY)		**20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES** ADMITTED / DISCHARGED	
C. HALL			
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)		**22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?** YES [ ] NO [X] CHARGES:	
MONTIFIORE MEDICAL CENTER 3331 BAINBRIDGE AVE. B			

23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE

1. 955.1 S/P LAC&REPAIR MEDIAN N. F-ARM
2. 728.9 WEAKNESS L. HAND
3.
4.

B. EPSDT YES [ ] NO [ ] FAMILY PLANNING YES [ ] NO [ ]

PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. * T.O.S.	H. LEAVE BLANK
02/25/91		0	90020	OFFICE MEDICAL SERVICE, NEW PATIENT;COMP	955.1 728.9	100 00	1	1	

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)

Specialty: Plast Reconstruc
BERISH STRAUCH, M.D.

DATE: 02/26/91

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES [X] NO [ ]

27. TOTAL CHARGE: 100 00

28. AMOUNT PAID: 0 00

29. BALANCE DUE: 100 00

30. YOUR SOCIAL SECURITY NO.

31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.

BERISH STRAUCH, M.D.
3331 BAINBRIDGE AVE.
BRONX NY 10467
(212) 920-5551

I.D.(NO) 006095

32. YOUR PATIENT'S ACCOUNT NO.: 2214

33. YOUR EMPLOYER I.D. NO.: 062263330

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

APPROVED BY AMA COUNCIL

Form HCFA-1500 (C 2) (1 84) Form OWCP-1500

/SU-0027 (2-PLY)

LOCAL 1199
NATIONAL BENEFIT FUND
P.O. BOX 731
NEW YORK NY 10019

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

FORM APPROVED OMB NO. 2938-0008

☐ MEDICARE (MEDICARE NO.) ☐ MEDICAID (MEDICAID NO.) ☐ CHAMPUS (SPONSOR'S SSN) ☐ CHAMPVA (VA FILE NO.) ☐ FECA BLACK LUNG (SSN) XX ☐ OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): GILADI, RONI
2. PATIENT'S DATE OF BIRTH: 03 05 52
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): GILADI, RONI
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): P.O. BOX 127 MILLBURN NJ 07041
   TELEPHONE NO.
5. PATIENT'S SEX: ☐ MALE XX ☐ FEMALE
6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE. INCLUDE ALL LETTERS): 112643264
7. PATIENT'S RELATIONSHIP TO INSURED: SELF XX SPOUSE ☐ CHILD ☐ OTHER ☐
8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
   ☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER): NONE REPORTED
10. WAS CONDITION RELATED TO:
    A. PATIENT'S EMPLOYMENT: YES ☐ NO XX
    B. ACCIDENT: AUTO ☐ OTHER ☐
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE): P.O. BOX 127 MILLBURN NJ 07041
    TELEPHONE NO.
    11a. CHAMPUS SPONSOR'S: STATUS ☐ ACTIVE DUTY ☐ RETIRED ☐ DECEASED BRANCH OF SERVICE
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.
    SIGNED SIGNATURE ON FILE DATE 07/22/91
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.
    SIGNATURE ON FILE
    SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES
16.a. IF EMERGENCY CHECK HERE ☐
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY FROM THROUGH
    DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY): C. HALL
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE): MONTEFIORE MEDICAL CENTER 3331 BAINBRIDGE AVE F
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO XX CHARGES:
23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE
    1. 955.1 S/P LAC&REPAIR MEDIAN N. F-ARM
    2. 728.9 WEAKNESS L. HAND
    3. 354.0 BIL MEDIAN NERVE COMPRESSION
    4.
B. EPSDT YES ☐ NO ☐ FAMILY PLANNING YES ☐ NO ☐ PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM	TO	B. * PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. * T.O.S.	H. LEAVE BLANK
02/25/91		0	90020	OFFICE MEDICAL SERVICE, NEW PATIENT;COMP	955.1 728.9	100 00	1	1	
07/19/81		0	20550	INJECTION, LEFT CARPAL TUNNEL	354.0	150 00	1	2	

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
    Specialty: Plas + Recon Surg
    BERISH STRAUCH, M.D.
    DATE: 07/22/91
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES XX ☐ NO
27. TOTAL CHARGE 250 00
28. AMOUNT PAID 0 00
29. BALANCE DUE 250 00
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.
    BERISH STRAUCH, M.D.
    3331 BAINBRIDGE AVE.
    BRONX NY 10467
    I.D.(#12) 920-5551
32. YOUR PATIENT'S ACCOUNT NO. 2214
33. YOUR EMPLOYER I.D. NO. 062263330

C06096

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

APPROVED BY AMA COUNCIL

Form HCFA-1500 (C-2) (1-84) Form OWCP-1500

LOCAL 1199
NATIONAL BENEFIT FUND
P.O. BOX 751
NEW YORK NY 10015

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

FORM APPROVED OMB NO. 0938-0008

☐ MEDICARE (MEDICARE NO.) ☐ MEDICAID (MEDICAID NO.) ☐ CHAMPUS (SPONSOR'S SSN) ☐ CHAMPVA (VA FILE NO.) ☐ FECA BLACK LUNG (SSN) XX ☐ OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): GILADI, RONI
2. PATIENT'S DATE OF BIRTH: 03 05 49
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): GILADI RONI
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): P.O. BOX 127 MILLBURN NJ 07041
5. PATIENT'S SEX: MALE [XX] FEMALE [ ]
6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS): 112643264
7. PATIENT'S RELATIONSHIP TO INSURED: SELF [XX] SPOUSE [ ] CHILD [ ] OTHER [ ]
8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.): ☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER): NONE REPORTED
10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES [ ] NO [XX]; B. ACCIDENT AUTO [ ] OTHER [ ]
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE): P.O. BOX 127 MILLBURN NJ 07041
11.a. CHAMPUS SPONSOR'S: STATUS ☐ ACTIVE DUTY ☐ DECEASED ☐ RETIRED; BRANCH OF SERVICE
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING): I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.
SIGNED: SIGNATURE ON FILE DATE: 08/05/91
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.
SIGNATURE ON FILE
SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES
16.a. IF EMERGENCY CHECK HERE ☐
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE): MONTEFIORE MEDICAL CENTER 3331 BAINBRIDGE AVE
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [XX] CHARGES:
23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE
1. 955.1 S/P LAC&REPAIR MEDIAN N. F-ARM
2. 354.0 BIL MEDIAN NERVE COMPRESSION
3.
4.

8. EPSDT YES [ ] NO [ ]; FAMILY PLANNING YES [ ] NO [ ]
PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM	TO	B. * PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. * T.O.S.	H. LEAVE BLANK
07/31/91		0	90060	OFFICE MEDICAL SERVICE, ESTABLISHED PT	955.1 354.0	50 00	1	2	

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF): Specialty Plastic Surg
BERISH STRAUCH, M.D.
DATE: 08/05/91
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES [XX] NO [ ]
27. TOTAL CHARGE: 50 00
28. AMOUNT PAID: 0 00
29. BALANCE DUE: 50 00
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.
BERISH STRAUCH, M.D.
3331 BAINBRIDGE AVE.
BRONX NY 10467
(212) 920-5551
32. YOUR PATIENT'S ACCOUNT NO.: 2214
33. YOUR EMPLOYER I.D. NO.: 062263330

C0S097

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON REVERSE

LOCAL 1199
NATIONAL BENEFIT FUND
P.O. BOX 791
NEW YORK NY 10019

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

FORM APPROVED OMB NO. 0938-0008

☐ MEDICARE (MEDICARE NO.) ☐ MEDICAID (MEDICAID NO.) ☐ CHAMPUS (SPONSOR'S SSN) ☐ CHAMPVA (VA FILE NO.) ☐ FECA BLACK LUNG (SSN) XX ☐ OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
BILADI, RONI	03 / 05 / 52	BILADI, RONI
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	**5. PATIENT'S SEX**	**6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)**
P.O. BOX 127 MILLBURN NJ 07041	MALE [X] FEMALE [ ]	112643364
TELEPHONE NO.	**7. PATIENT'S RELATIONSHIP TO INSURED** SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ]	**9. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)** [ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)	**10. WAS CONDITION RELATED TO:**	**11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)**
NONE REPORTED	A. PATIENT'S EMPLOYMENT YES [ ] [XX] NO B. ACCIDENT AUTO [ ] [ ] OTHER	P.O. BOX 127 MILLBURN NJ 07041 TELEPHONE NO.
		11.a. CHAMPUS SPONSOR'S: STATUS [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED — BRANCH OF SERVICE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

SIGNED SIGNATURE ON FILE DATE 10/08/93

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.

SIGNATURE ON FILE
SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF:	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES	16.a. IF EMERGENCY CHECK HERE
				[ ]

17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM	THROUGH	DATES OF PARTIAL DISABILITY FROM	THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)	20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
	ADMITTED 12/12/91 DISCHARGED 12/13/91

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)	22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
MONTIFIORE MEDICAL CENTER 3331 BAINBRIDGE AVE. B	YES [ ] [X] NO CHARGES:

23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE

1. 354.0 CARPAL TUNNEL SYNDROME
2.
3.
4.

B. EPSDT YES [ ] NO [ ]
FAMILY PLANNING YES [ ] NO [ ]
PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. * T.O.S.	H. LEAVE BLANK
10/06/93		0	99212	ESTABLISHED PATIENT, OFFICE MEDIC. HIST.	354.0	50 00	1	1	

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)	26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK)	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
Specialty Plas + Recon Surg BERISH STRAUCH, M.D. DATE: 10/08/93	YES [X] NO [ ]	50 00	0 00	50 00
32. YOUR PATIENT'S ACCOUNT NO.	**33. YOUR EMPLOYER I.D. NO.**	**30. YOUR SOCIAL SECURITY NO.**	**31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.**	
2214	062263330		BERISH STRAUCH, M.D. 3331 BAINBRIDGE AVE. BRONX NY 10467 (212) 920-5551	009098